COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES

Division of Consolidated Laboratory Services

600 N 5th St. Richmond VA 23219

Clinical Microbiology//Virology Request Form

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Patient Information (Please Print)

2 3

Name JOHNSON, (Last) BETTY (First) M. (Middle Initial) DOB __MM_/DD_/_YYYY_ (mm dd yyyy) Age_55___ ○M XF

Pt Address PATIENT ADDRESS City_____, State_____ Zip Code _____

4

City/County of Residence_____

UNIQUE PATIENT IDENTIFIER FOR YOUR FACILITY HERE…

Medical Record/Chart/Accession#_____ Patient ID_____…OR HERE

5

Marital Status: ○ single ○ married ○ separated ○ divorced ○ widowed ○ unknown

Race: X Black ○ White ○ Asian ○ AI/AN ○NH/PI ○ Other _____ **Ethnicity:** X Hispanic/Latino ○ Not-Hispanic/Latino

(check all that apply)

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Submitter Information

Submitter Code # _____ Site code_____ FIPS code_____

Send Report to:

Submitter MUST MATCH THE NAME OF YOUR FACILITY AS IN DCLS DATABASE Submitter Phone XXX-XXX-XXXX

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Submitter Address ADDRESS OF YOUR FACILITY AS IN DATABASE City _____, State ____ Zip code_____

Attending Clinician DOC

Attending Clinician Phone # FACILITY - PHONE - NUM

District or PH Contact_____

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Site Type

○ STD	○ ATS	○ DCJ	○FP	○ GYN	x Priv Phys
○ OB/prenatal care	○ AHC	○ Field	○ IMM	○ Job Corp	○ Peds
○ TB	○ GMC	○ CHC	○ DTC	○ Refugee	○ SOI
x Hospital	○ OCME	○ Student HC		○ Other _____	

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Patient Medical History

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Disease suspected/Diagnosed INFLUENZA

11

Signs/Symptoms

12

□ Asymptomatic X Fever □ Respiratory □ Bloody sputum Date of Onset: __MM_/DD_/_YYYY (mm dd yyyy)

X Cough □ Productive cough □ Rash □ Vomiting Deceased Date: _____/_____/_____ (mm dd yyyy)

□ Diarrhea □ Stool + Blood □ Stool + Mucous □ Abdominal Pain

□ Apnea □ SIDS □ Sudden Unexplained Death Vaccine Administered_____ (Please specify)

X Other SORE THROAT Vaccine Administration Date_____/_____/_____ (mm dd yyyy)

Recent Exposure (if applicable) □ Birds □ Ticks □ Mosquitoes Antibiotics/Anti-Viral Used _____ (Please specify)

□ Other _____ Antibiotics/Anti-Viral Start Date _____/_____/_____ (mm dd yyyy)

Special Information for Laboratorians LEAVE BLANK

Outbreak Related □ no □ yes Outbreak Number: _____

Role of Patient (ex. food-handler, patron):_____

□ Other Information_____

FOR FLU SURVEILLANCE YOU DO NOT NEED TO COMPLETE PAGE 2; STOP HERE

*Complete information on back

DCLS

INSTRUCTIONS FOR FILLING OUT LAB FORM FOR SENTINEL SURVEILLANCE OF SUSPECTED INFLUENZA CASES

FOR SENTINEL FLU SURVEILLANCE, ONLY THE FIELDS MARKED IN **RED** ARE REQUIRED. PLEASE WRITE CLEARLY.

1. PATIENT NAME, LAST NAME FIRST. THIS MUST EXACTLY MATCH THE NAME AS WRITTEN ON THE LAB SPECIMEN TUBE
2. PATIENT AGE / DOB MUST EXACTLY MATCH THE DATA AS WRITTEN ON THE LAB SPECIMEN TUBE
3. PLEASE INDICATE PATIENT GENDER
4. PLEASE FILL IN PATIENT'S ADDRESS OF RESIDENCE
5. YOUR FACILITY'S ID NUMBER FOR THE PATIENT. ONLY ONE IS NEEDED.
6. PLEASE INDICATE PATIENT'S RACE / ETHNICITY
7. YOUR FACILITY'S NAME AND CONTACT DATA MUST MATCH THOSE GIVEN TO THE STATE LABORATORY FOR YOUR SITE. IF UNSURE, PLEASE CHECK WITH YOUR DISTRICT EPIDEMIOLOGIST.
8. NAME AND PHONE NUMBER OF RESPONSIBLE PHYSICIAN OR CLINICIAN
9. PLEASE INDICATE: SITE IS *EITHER* A PRIVATE PRACTICE **OR** HOSPITAL / ER / URGENT CARE CENTER
10. ALWAYS, INDICATE *FLU* OR *INFLUENZA*
11. PATIENT **MUST** HAVE FEVER plus COUGH **and / or** SORE THROAT IN ORDER TO MEET SURVEILLANCE CRITERIA. FEVER **MUST** BE MINIMUM OF 100° F
12. DATE OF ONSET: PLEASE INDICATE WHEN SYMPTOMS BEGAN

BEYOND THESE 12 FIELDS, NO OTHER INFORMATION IS REQUIRED. SECOND PAGE NOT REQUIRED. THANK YOU! ☺